TEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I '	E CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY TED
PLAN OF	CORRECTION		A. BUILDING  B. WING		07/3	0/2010 _
	ROVIDER OR SUPPLIER	09G056	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
OMP CA				1 EMERSON STREET NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	/= 4 OL + DEELCIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETIO DATE
W 000	INITIAL COMME	NTS	W 000			
W 120	28, 2010, through fundamental survive males with viretardation and control of the findings of the fundamental survive fundamen	ne survey were based on he group home and three day iews with clients and staff, and nical and administrative records at reports.  ERVICES PROVIDED WITH RCES	W 120	Received	A refo	
	This STANDAR Based on obser review, the facil	D is not met as evidenced by: vation, interview, and record ity failed to ensure that outside e needs of each client, for one of the sample. (Client #2)				
	The facility faile implemented C prescribed.	d to ensure that the day program lient #2's behavior support plan as			·	
	28, 2010, at 11 leaning over the qualified menta told the client he surveyor her percame to the date.	Client #2's day program on July :31 a.m., revealed the client e surveyor. At the same time, the al retardation professional (QMRP) he was too close and to give the ersonal space. (Note: the QMRP by program to give him his eye				(X6) DA
ABORATO	DRY DIRECTOR'S OR P	ROVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	Jdm. Host.		8/16/10_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM APRICATOR

TATEMENT	NTERS FOR MEDICARE & MEDICALLY SERVICES  EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G056		A. BUILE	LTIPLE CONSTRUCTION DING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/30/2010		
		09G056			0713	30/2010	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE	
W 124	the surveyor and he with his day program program staff requesurveyor her personal surveyor her personal staff requesurveyor her personal staff to stand within arm their personal space. Review of the day (BSP) dated Octob 12:40 p.m., reveale addressing Client # inappropriate social a. Staff should "ask way to remind him b. He should receive conversation in an c. If he continues he disengage, physical him until he uses the day program #1's BSP.  483.420(a)(2) PRORIGHTS  The facility must er Therefore the facility parent (if the client of the client's mediand behavioral staff requests the day program of the client's mediand behavioral staff requests the staff requests and behavioral staff requests the staff requests requests the staff requests	p.m., Clien! #2 stood close to eld her hand while she spoke m staff. At no time did the day est the client to give the nal space.  Lay program staff at 12:35 he is required to ask the client is length and to give individuals ite.  Drogram behavior support planter 20, 2009, at approximately ed the following procedures for this target behavior of	W 12	W 120 A case conference will I with client #2's day proto discuss consistency in implementing intervent specified in the Behavior Support Plan (BSP).  Twice monthly, for the three months, the Qual Mental Retardation Professional (QMRP) we client#2 at his day progobserve implementation interventions specified BSP.	gram n tions or next ified vill visit gram to n of the	08/31/10	

CENTE	RS FOR MEDICARE	& MEDICA - SERVICES			OMB NO	0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	(X3) OATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILI	DING	COMILE	EILD
		09G056	B. WING	<u> </u>	07/	30/2010
NAME OF P	ROVIDER OR SUPPLIER		[s	STREET ADDRESS, CITY, STATE, ZIP COD	· · · · · · · · · · · · · · · · · · ·	
COMP C	AREII			1321 EMERSON STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
W 124	Continued From pa	ge 2	W 12	24		
	Based on observation review, facility failed would ensure client legal guardians were benefits of restrictive two of the three clies (Clients #1 and #3). The findings included 1. The facility failed informed consent we family member for previdenced below:  During the entrance beginning at 10:00 a retardation professis Client #1 had family client in making heat a. Observations duadministration, on Jevealed that Client and Zyprexa 5 mg. Practical Nurse (LP administration indicathe aforementioned maladaptive behavior and provided that contains the second profession of the aforementioned maladaptive behavior and the second profession of the s	I to provide evidence that was obtained from Client #1's obsychotropic medications as expected conference on July 28, 2010, a.m., the qualified mental onal (QMRP) indicated that was members who assisted the alth care decisions.  I ring the medication uly 29, 2010, at 7:11 a.m., #1 received Tegretol 300 mg Interview with the Licensed N) after the medication atted that the client received medication for his ors.  I's current physician orders July 29, 2010, at		W 124, 1a The facility will adhere obtaining consent for psychotropic medication timely manner.  Consent shall be obtained a family member and/or guardian before newly prescribed psychotropic medications or sedative hypnotic drugs are administered.	ns in a	08/25/10
		dications. In addition, the Remeron 30 mg, by mouth, at				

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CENTE	RS FOR MEDICARE	& MEDIC, J SERVICES				OMB NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G056	B. WII	NG_		07/30	)/2010
NAME OF P	PROVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 124	bedtime. According mg was written on a increased to 30 mg. Review of Client #1 dated January 15, 2 approximately 3:00 was not competent his health, safety, fi placement. Further failed to provide evi had been obtained. Further review of the signed consent date consent form was 1 day, Tegretol 600 m Zyprexa 5 mg, in the evening and Reflectionsent for the Render However, once the consent from Client b. Review of Client 2010, on July 29, 20 a.m., revealed and bedtime. Further readministration recording that the Capproximately 9:30 assessment dated at the assessment,	ge 3 g to the POS, the Remeron 15 August 20, 2009, and on January 26, 2010.  's Psychological Assessment 2010, on July 29, 2010, at p.m., revealed that the client to make decisions regarding nancial or residential review of the client's record dence that informed consent for the use of the Remeron. e client's record revealed a ed June 23, 2010. On the regretol 300 mg, three times a ng, every evening (weekends), e morning Zyprexa 20 mg, in meron 30 mg, at bedtime.  MRP on July 30, 2010, at 0 p.m., indicated that the neron was not obtained timely. QMRP realized he obtained at 1's family member.  #1's POS dated August 20, 010, at approximately 9:30 order for Zoloft 50 mg, at eview of the medication rd (MAR) on July 29, 2010, client received the prescribed. 2009, through August 25,  's record on July 29, 2010, at a.m., revealed a psychological January 15, 2010. According Client #1 "is not able to make ons concerning his residential	<b>W</b>	124			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

### The second secon P. Marie Land PRINTED: 08/06/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICALL SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 09G056 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE 11** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION łΩ (X4) ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG **TAG** DEFICIENCY) W 124 Continued From page 4 W 124 W 124, 1b or day placements. He lacked the cognitive skills Consent shall be obtained from necessary to understand the implications of such decisions and therefore cannot give her informed a family member and/or consent. He lacked the judgment and insight guardian in a timely manner required to make decisions independently." before newly prescribed Further review of the record revealed no evidence psychotropic medications or of a signed consent for the prescribed Zoloft. sedative hypnotic drugs are The facility failed to provide evidence that the administered. potential risks involved in using this medication, or his right to refuse treatment had been Client #1 shall be informed of explained to the client and/or guardian, prior to the risks involved in taking his the implementation of the psychotropic medication. prescribed medications, and his right to refuse treatment. 2. The facility failed to provide evidence that Such rights shall be reviewed informed consent was obtained from Client #3's with client#1 annually or as family members for sedation given during medical needed. appointments as evidenced below: 08/31/10 During the entrance conference on July 28, 2010. beginning at 10:00 a.m., qualified mental retardation professional (QMRP) indicated that Client #3 had an active family member to assist the client in making health care decisions. Review of Client #3's physician orders (POS) on July 30, 2010, beginning at 11:00 a.m., revealed the following orders: - On July 19, 2010, Ativan 4 mg, prior to dental examination: and - On July 23, 2010, Ativan 2 mg, prior to laboratory studies.

Review of Client #3's medication administration record (MAR), confirmed that the client was administered the aforementioned sedations.

DEPAR		I AND HUM 'N SERVICES & MEDICAL SERVICES		AND SERVICE TO SERVICE SERVICE SERVICE SERVICE SERVICE SERVICES	FORM	0: 08/06/2010 MAPPROVED 0: 0938-0391
STATEMEN <sup>*</sup>	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	MULTIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW	:	
	<b>y</b>			WASHINGTON, DC 20011		- <del></del>
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W 124	Continued From pa	ge 5	W	124		
W 149	Further record revied dated May 27, 2010 for Ativan 2 mg, pripodiatry examination dental appointment was not included or Furthermore, the climg and the signed 2 mg. Interview with at approximately 1: not aware of the labthe use of Ativan 4 appointment.  Review of Client #3 dated October 20, 2 beginning at 12:30 was not competent his health, safety, fiplacement. Further failed to provide evidence thin using this medical treatment had been family members.  483.420(d)(1) STAF CLIENTS  The facility must depolicies and proced mistreatment, negles.	ew revealed signed consents  D. The signed consents were or to an ophthalmology, and ons, and Ativan 4 mg, prior to  Laboratory studies consult in the signed consent form. Ident was sedated for Ativan 4 consent was signed for Ativan in the QMRP on July 30, 2010, 30 p.m., revealed that he was coratory studies consult and img, for the schedule dental  The Seychological Assessment 2009, on July 30, 2010, p.m., revealed that the client to make decisions regarding mancial or residential the review of the client's record dence that informed consent for the use of the sedation.  The server of the sedation.  The Seychological Assessment to make decisions regarding mancial or residential the review of the client's record dence that informed consent for the use of the sedation.  The server of the client and/or the potential risks involved tion, or his right to refuse explained to the client and/or  The TREATMENT OF  The server of the client.		W 124, 2. There was a breakdown communication between facility's nurse and the in specifying the use of sedation. And as such, to consent for sedation was sought. A communication book will be put in place will foster communication between the nursing department and the QM issues such as sedation, psychotropic medication other restrictions.  Consent for sedation will tracked and sought in a manner in the future.	the QMRP he s not on e which on IRP on and	08/31/10
	Based on interview	and record review, the facility cies that prohibit mistreatment				

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	OMB NO. 0938-0391	
- •	(X3) DATE SURVEY COMPLETED	

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W 149	or abuse were consof three clients included (#3).  The findings included The facility failed to management policy Review of Client #3 2010, on July 30, 20 p.m., revealed that Client #3 across the review revealed that Practical Nurse add Interview with the CProfessional (QMR) approximately 2:30 unaware of the incider revealed there was According to the revealed that reportable or report further revealed that serious reportable in both verbally reported incidents an incident report streportable incidents the facility failed to emanagement policy	esistently implemented for one uded in the sample. (Client and in the sample. (Client esistently implemented as outlined. It is nursing note dated April 5, 210, at approximately 1:00 a client at the day program hit eleft side of his face. Further at the facility's License ininistered Tylenol for pain.  Aualified Mental Retardation P) on July 30, 2010, at p.m., revealed he was dent. Further interview no incident report completed. View of the facility's incident on July 28, 2010, at a.m., it revealed that all fied into either a serious able incident. The policy that all fied into either a serious able incident. The policy that abuse was classified as a incident that should have been ed immediately to the facility's or and to the Department of the incident should have been an incident report form and the partment of Health. It should the policy also indicated that anould be completed for all. At the time of the survey, ensure that its incident was implemented as outlined.	W 1		W 149 Direct Care Staff (DCS) a nurses will be re-trained of facility's incident manage policy. Such training will be held quarterly so as to enhance understanding and competency in incident management policy and procedure.	on the ment	08/31/10

		I AND HU! "AN SERVICES & MEDIC) SERVICES		·		FORM	. 08/06/2010 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			URVEY TED
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W 153	Continued From pa CLIENTS	ge 7	W 1	53			
	mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other acce with State law through ures.			W 153 Cross reference W 149.		
	Based on interview records, the facility incidents of abuse immediately to the a	s not met as evidenced by: and review of the client's failed to ensure that all were consistently reported administrator and to the State he thee clients included in the )					
ı	The finding includes	s:					
	2010, on July 30, 20 p.m., revealed that a Client #3 across the review revealed that	s nursing note dated April 5, 010, at approximately 1:00 a client at the day program hit left side of his face. Further the facility's License hinistered Tylenol for pain.					
W 192	Professional (QMRF approximately 2:30 unaware of the incide revealed there was a At the time of the suthat the facility report the administrator or	ualified Mental Retardation P) on July 30, 2010, at p.m., revealed he was lent. Further interview no incident report completed. Irvey, there was no evidence rted the incident of abuse to to the Department of Health. F TRAINING PROGRAM	W 19	42			

For employees who work with clients, training must focus on skills and competencies directed

### PRINTED: 08/06/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC. ... D SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: CDMPLETED A. BUILDING B. WING 09G056 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CDRRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CRDSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) W 192 Continued From page 8 W 192 toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that staff followed client's meal time protocol and physician orders, for one of the three clients included in the sample. (Client #2) The finding includes: W 192 On July 28, 2010, direct care staff was observed preparing Client #1's snack. The client had a All staff will be re-trained on choice of apples (cut into quarters), plums, fresh diet type, texture, and portion peaches (whole) and graham crackers (broken in control. half). The client choose the peach. At 5:53 p.m., Client #1 was observed eating dinner. The meal The House Manager and the consisted of penne pasta, shredded cabbage, pasta sauce, canned fruit pears and beverage. facility's Licensed Practical Nurse (LPN) will on a daily Interview with the direct care staff, who prepared basis (5 days a week) observe the client's meal on July 28, 2010, at 6:05 p.m., staff in demonstrating revealed that the client was on a low sodium. competency in adhering to diet finely chopped meats and vegetable diet. Review of the current physician orders dated July 2010. type, texture, and portion revealed a diet order of low cholesterol, low control. Such observations sodium, finely chopped meats and vegetables shall be done for three months. A staff found not to be in On July 29, 2010, at 11:30 a.m., interview with the license practical nurse revealed that if a client is compliance with diet orders ordered a finely chopped meal, they should not will be provided with one-onreceive shredded vegetables. 08/31/10 one in-service and supervision.

Review of the facility's in-service training records on July 30, 2010, at 9:50 a.m., revealed that all staff had received nutritional training on May 11, 2010. There was no evidence that training had

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION  DING	(X3) DATE : COMPL		
		09G056	B. WIN	G	07/3	30/2010	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 192		ge 9	W 1	92			
W 227	been effective. 483.440(c)(4) INDIV	VIDUAL PROGRAM PLAN	W 2	27			
	objectives necessa as identified by the	ram plan states the specific ry to meet the client's needs, comprehensive assessment uph (c)(3) of this section.					
	Based on observati review, the facility fa Individual Program to meet the client's the comprehensive	s not met as evidenced by: on, interview and record ailed to ensure that the Plan (IPP) included objectives needs as recommended from functional assessments, for ents in the sample. (Client #1)					
	The finding includes	s:	-	,		i	
	revealed direct care his shower. Intervie same date, at 6:50	ly 28, 2010, at 6:15 p.m., e staff assisting Client #3 with ew with direct care staff, on the p.m., indicated that he has to a shower, to include lathering insing him.		W 227 An Individual Prog (IPP) will be put in which will be geare	place d towards		
	and Occupational T October 20, 2009 ar respectively on July 10:45 a.m., revealed for the client to parti The program should directive for him to s shower head to was IPP dated October 2 11:00 a.m., revealed	t#1's Psychology assessment herapy assessment dated and October 1, 2009, 30, 2010, at approximately a program recommendation cipate in a showering routine. I provide simple step by step soap himself and use the h off the soap. Review of the 23, 2009, on July 30, 2010, at in no evidence of training is the aforementioned		enhancing client #1 participating in sho routine. Such progr monitored quarterl progress.	wer ram shall be	08/25/10	

### PRINTED: 08/06/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC, ... J SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G056 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) W 227 Continued From page 10 W 227 recommendations included in the comprehensive functional assessment. The QMRP verified on July 30, 2010, at approximately 12:45 p.m., that no training programs had been developed for the client to participate in a showering program as recommended in the aforementioned assessments. W 249 483.440(d)(1) PROGRAM IMPLEMENTATION W 249 As soon as the interdisciplinary team has formulated a client's individual program plan. each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure client's received continuous active treatment, for two of the three clients included in the sample. (Clients #1and #3)

This STANDARD is not met as evidenced by:

The findings include:

1. During medication administration observation on July 29, 2010, at 7:11 a.m., revealed Licensed Practical Nurse #1 (LPN #1) placed a cup of medications into Client #1's hands in order for the client to consume the medication with two (2) physical prompts. Further observation revealed Client #1 picked up a cup of water and consumed

W 249, 1.

All of the clients in the facility have self medication programs. The facility's LPN and Direct Care Staff will be re-trained on implementing the selfmedication programs.

The facility's RN will, on a monthly basis observe the full implementation of the self medication programs.

08/25/10

# DEPARTMENT DF HEALTH AND HU\* "N SERVICES CENTERS FOR MEDICARE & MEDIC, ...) SERVICES

PRINTED: 08/06/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		•	132	ET ADDRESS, CITY, STATE, ZIP CODE 11 EMERSON STREET NW ASHINGTON, DC 20011		
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W 249	the contents with or During a face-to-face July 29, 2010, at apprevealed Client #1 however, the prograe evening.  Review of Client #1 dated July, 2010, or approximately 9:00 verbal assistance Comedications from a pack/bubble pack to per month. Further medication program a. Wash his hands; b. Identify medication program a. Wash his hands; b. Identify medication Put cup under medic. Punch meds  There was no evide the opportunity to fur medication program 2. During medication on July 29, 2010, at went into the kitcher cup on the counter a into Client #3's hand revealed LPN #1 he cups to Client #3's nonsume the medic physical prompts.  During a face-to-face July 29, 2010, at appreciation of the counter a consume the medic physical prompts.	the (1) verbal prompt.  The interview with LPN #1 on opposition program and a self-medication program arm was implemented in the self-medication program a.m., indicated that given a.m., indicated that given bingo card (blister a cup 60% of recorded trials review revealed the self-mass as follows:  The program of the self-mass as follows:  The program of the self-mass as follows:  The program of the self-mass as follows:	W	249	W 249, 2 Cross reference W249,1		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC D SERVICES

PRINTED: 08/06/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G056	B. WIN	G		07/:	30/2010
NAME OF F	PROVIDER OR SUPPLIER	1-41		132	ET ADDRESS, CITY, STATE, ZIP CODE 1 EMERSON STREET NW .SHINGTON, DC 20011		5072010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 262	however, the prograevening.  Review of Client #3 dated July, 2010, or approximately 9:10 verbal prompts, Clie with water when it is Further review reve program was as follows.  a. Wash hands; b. Get a cup; b. Fill cup with water. Go to medication.  There was no evide the opportunity to furmedication program 483.440(f)(3)(i) PROCHANGE.  The committee shown and the opinion of the client protection and the opinion of the client protection and the strictive measures approved by the Hurter approximate the supproved by the Hurter approximately approved by the Hurter approximately approx	am was implemented in the as a self-medication program of July 29, 2010, at a.m., indicated that given ent #3 will get his cup and fill it is time for his medications. aled the self-medication lows:  If and dispensation area of the self-medication lows:  If and medication lows:  If and dispensation area of the self-medication lows:  If and review, approve, and regrams designed to manage in and other programs that, committee, involve risks to a rights.  If anot met as evidenced by:  If anot met as evidenced and/or man Rights Committee of clients in the sample.	W 2				

### PRINTED: 08/06/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC. ....) SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) W 262 Continued From page 13 W 262 Minutes taken at meetings of the facility's HRC for the period July 2009 through June 2010, were reviewed on July 29, 2010, beginning at 2:10 p.m. According to the documents, sedations are part of the review process. Review of Client #3's medical chart on July 30. 2010, beginning 12:15 p.m., revealed the following orders: - On July 6, 2010, Ativan 4 mg, prior to podiatry examination; - On July 19, 2010, Ativan 4 mg, prior to dental examination; and - On July 23, 2010, Ativan 2 mg, prior to laboratory studies. Interview with the qualified mental retardation professional (QMRP)on July 30, 2010, at approximately 1:30 p.m., revealed that Client #3 received the sedation to address his W 262 non-compliance prior to the medical appointments. Record review revealed HRC In accordance with W124 (2): meeting notes dated May 31, 2010. The HRC when communication for the minutes approved for Client #3 to receive Ativan 2 need of sedation in exact dose mg for medical appointments (dental and

FORM CMS-2567(02-99) Previous Versions Obsolete

medical appointments.

podiatry). Further review revealed no evidence

that the facility's HRC reviewed and/or approved

Further interview with the QMRP, at 1:55 p.m.,

indicated that he thought Client #3 was going to

There was no evidence, however, that the HRC reviewed and/or approved the use of Ativan 4 mg

receive Ativan 2 mg for the above mentioned

Ativan 2 mg prior to a laboratory study.

Event ID: 5QSD11

Facility ID: 09G056

and purpose is conveyed to the

OMRP through the established

communication book, the Human Rights Committee will

convene to discuss the pros

provide approval or

disapproval.

and cons of such sedation and

If continuation sheet Page 14 of 19

08/31/10

### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDIC**

PRINTED: 08/06/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G056	B. WII			07.6	0/0040
NAME OF	PROVIDER OR SUPPLIER	030000		етг	REET ADDRESS, CITY, STATE, ZIP CODE	1 07/3	0/2010
COMP				1	321 EMERSON STREET NW VASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 262	for the dental and puse of Ativan 2 mg 482.460(a)(3)(iii) Pl The facility must prexaminations of earningludes routine screxaminations as dephysician.  This STANDARD is Based on interview, failed to provide roudetermined necessithree clients includes. The finding includes. The facility failed to ordered by the Primers.	odiatry appointments and the for a labortory study. HYSICIAN SERVICES ovide or obtain annual physical ch client that at a minimum reening laboratory termined necessary by the s not met as evidenced by: and record review, the facility tine laboratory testing as ary by the physician, for one of ed in the sample. (Client #3)		262	W 325		
W 336	July 1, 2009, to July 12:30 p.m., revealed have laboratory stude every year. Subseque records revealed the 2009. There were not the client's record. Interview with the licon July 30, 2010, at confirmed that the lacompleted as ordere 483.460(c)(3)(iii) NU. Nursing services mu	d 2010, on July 30, 2010, at d an order for the client to dies for CBC and urinalysis uent review of his medical e last CBC study was May 27, to laboratory results available for a urinalysis study.  The sense practical nurse (LPN) approximately 1:00 p.m., aboratory studies were not ed.	<b>w</b> 3	36	Quarterly Audits will be conducted on all habilitate records to ensure that all recommendations and me appointments are followers as recommended and in a timely manner.	edical d up	08/31/10

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDIC  J SERVICES	:		FOR OMB N	D: 08/06/20 M APPROVE O. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		09G056	B. WIN	G	07	/30/2010	
IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 336	review of their healt quarterly or more fr client need.  This STANDARD is Based on interview facility's registered in	iew of their health status which must be on a arterly or more frequent basis depending on int need.  s STANDARD is not met as evidenced by: sed on interview and record review, the dilty's registered nurse (RN) failed to ensure resical examinations were conducted quarterly		36			
	or on a more freque	ent basis, for three of the three ne sample. (Client #, #2 and					
Parent number nu	Nurse (LPN) Coordi approximately 9:30 Registered Nurse (F nursing exams. Re- record on July 29, 2 nursing assessment Further record revienursing reviews. The	e facility's Licensed Practical inator on July 29, 2010, at a.m., revealed that the RN) should complete quarterly view of Client #1's medical 010, at 10:00 a.m., revealed a t dated January 8, 2010. w revealed no quarterly se LPN Coordinator confirmed quarterly reviews for Client		W 336, 1. Quarterly Audits will conducted by the Quarters (OA) staff	lity		
	29, 2010, at 9:36 a.r nursing assessment Further review of the there was no nursing record after October License Practical Nuat 10:28 a.m., revea	#2's medical record on July m., revealed an annual dated April 12, 2009. e client's record revealed g quarterly assessment in the 20, 2009. Interview with the urse (LPN) on July 30, 2010, led that nursing quarterlies empleted every quarter (3		Assurance (QA) staff that all assessments a completed and filed a required.  336, 2 See W336, 1.	re	08/31/10	
	,						

		AND HUMAN SERVICES & MEDIC		and the second of the second o	FORM	: 08/06/2010 I APPRÖVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Ī	IULTIPLE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
09G056			B. WII	NG	07/3	30/2010
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COMP	AREII			1321 EMERSON STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
W 336	3. Review of Client 30, 2010, at 12:10 pursing assessmen Further review of the there was no nursing to April 2010. Interview (LPN) on July 10:30 a.m., revealed required to be components).	#3's medical record on July o.m., revealed an annual t dated October 1, 2009. The client's record revealed g quarterly assessment prior view with the License Practical of 30, 2010, at approximately that nursing quarterlies are eleted every quarter (3	W:			
W 362			W	W 362 The pharmacist has bee informed of the require to conduct reviews quar Quarterly Audits will be conducted by the Qualit Assurance staff to ensur pharmacy reviews are conducted every three m (quarterly) instead of ev four (4) months.	ment terly.  y te that	08/31/10

### PRINTED: 08/06/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC, USERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G056 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE 11 WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) W 362 Continued From page 17 W 362 Interview with the facility's LPN Coordinator on July 29, 2010, at approximately 2:00 p.m., confirmed that the pharmacy reviews were completed every four months. W 436 483.470(g)(2) SPACE AND EQUIPMENT W 436 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces. and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the timely provision of assistive devices (dentures) recommended by the interdisciplinary team for one of three clients in the sample. (Client #2) W436 The finding include: A portion of the Quality Assurance audit will be. On July 28, 2010, at 11:15 p.m., Client #2 was auditing of timely completion observed with no teeth. Review of Client #1's of medical appointments medical record on July 28, 2010, at 5:10 p.m., and/or implementation of revealed a nursing progress note dated June 29. 2010. The progress note stated that the client recommendations. broke his upper dentures. The next nursing progress note dated July 28, 2010, revealed the The facility's RN will on a License Practical Nurse (LPN) scheduled an

dental appointment for August 13, 2010.

Interview with the (LPN) on July 29, 2010, at

approximately 2:30 p.m., indicated Medicaid

would not cover Client #2's dentures until 2012. Further interview revealed that the LPN made an appointment after the qualified mental retardation monthly basis review all

a timely manner.

medical records to ensure that

appointments are completed in

08/31/10

		I AND HUMAN SERVICES  & MEDIC	-		•		APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	09G056		B. WING			07/30/2010		
NAME OF PROVIDER OR SUPPLIER  COMP CARE I			STREET ADDRESS, CITY, STATE, ZIP CODE  1321 EMERSON STREET NW  WASHINGTON, DC 20011					
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W 436	dental school. At th	ge 18 sted that she call the hospital's le time of the survey, the ure Client #1 received timely	W	436				
						!		
							·	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/06/2010

Health R	Regulation Administra	ation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N  HFD03-134			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 07/30/2010			
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE			
1321 EME			ERSON STREET NW GTON, DC 20011					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
ı 000	INITIAL COMMENTS			1 000				
	2010, through July of three residents wo of five males with woretardation and disarrangements. The findings of the observations at the programs, interview	survey were based of group home, three d ws with residents and al and administrative	n sample copulation tal on day staff, and					
ı 090	3504.1 HOUSEKEI	EPING		I 090				
	maintained in a saf	terior of each GHMR fe, clean, orderly, attra er and be free of lirt, rubbish, and objec	active,					
	Based on observati Home for Persons (GHMRP) failed to exterior of the facilit	met as evidenced by ion and interview, the with Mental Retardati maintain the interior at ity in a safe, clean, or tary manner for five on the facility.	Group ion and derly,					
	The findings include	e:						
	Program Manager	terview with the facilit (PM) on July 29, 2010 ximately 10:45 a.m., r	ó, [					
	Interior:							
	1. The entrance ha	allway ceiling had crad	cks and					

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Adm. Mad.

(X6) DATE

8/16/10

If continuation sheet 1 of 15

PRINTED: 08/06/2010 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-134 07/30/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1090 1090 Continued From page 1 I 090 water stains. 1. The entrance hallway will be repaired 2. The first floor den ceiling had water damage. 2. The first floor bathroom ceiling will be 3. The first floor bathroom ceiling had water damage. repaired. The Program Manager (PM) acknowledged the Monthly environmental audits above deficiencies on July 29, 2010, at (internal and external audits) approximately 11:30 a.m. will be conducted by the maintenance division to ensure I 191 3508.8(b) ADMINISTRATIVE SUPPORT 1191 that all maintenance issues are Each GHMRP licensee shall carry or ensure that resolved in a timely manner. the premise carries the following insurance in at 08/31/10 least the following amounts: (b) Liability coverage (premises, personal injury, I 191 and products liability in the amount of three Medication Nurses #4 and #5 hundred thousand dollars (\$ 300,000)) per occurrence; and Professional liability. are employees of Comprehensive Care II, Inc. This Statute is not met as evidenced by: Thus, they do not need liability Based on record review and interview, the Group Insurance. Home for Persons with Mental Retardation (GHMRP) failed to have on file for review, Registered Nurse #2 and professional liability insurance, for four of eleven consultants. (Registered Nurse #2, two Med. Pharmacist #9 have been Nurses #4 and #5, and the Pharmacist #9) requested to submit their liability insurance. The finding includes:

Review of the personnel records on July 29, 2010, at approximately 1:30 p.m., revealed the

Medication Nurses and the Pharmacist.

House Manager on July 29, 2010, at

GHMRP failed to have evidence of professional

liability insurance for the Registered Nurse, two

These deficiencies were acknowledged by the

The Assistant Administrator

all folders of staff and

consultant to ensure that

required documents are

updated as needed.

will, on a monthly basis check

08/31/10

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FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-134 07/30/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1191 Continued From page 2 1191 approximately 1:45 p.m. 1229 3510.5(f) STAFF TRAINING 1229 Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition. I 229 recreation, total communications, and assistive All staff will be re-trained on technologies: diet type, texture, and portion This Statute is not met as evidenced by: control. Based on observations, staff interview and record verification, the Group Home for Persons with The House Manager, and the Mental Retardation (GHMRP) failed ensure staff facility's Licensed Practical received effective training in the area of nutrition. Nurse (LPN) will on a daily for one of the three residents included in the sample. (Resident #1) basis (5 days a week) observe staff in demonstrating The finding includes: competency in adhering to diet type, texture, and portion On July 28, 2010, direct care staff was observed control. Such observations preparing Resident #1's snack. The client had a choice of apples (cut into quarters), plums, fresh shall be done for three months. peaches (whole) and graham crackers (broken in A staff found not to be in half). The resident choose the peach. At 5:53 compliance with diet orders p.m., Resident #1 was observed eating dinner. will be provided with one-on-The meal consisted of penne pasta, shredded 08/31/10 cabbage, pasta sauce, canned fruit pears and one in-service and supervision. beverage. Interview with the direct care staff, who prepared Resident #1's meal on July 28, 2010, at 6:05

p.m., revealed that the resident was on a low sodium finely chopped meats and vegetable diet. Review of the current physician orders dated July 2010, revealed a diet order of low cholesterol, low sodium, finely chopped meats and vegetables

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FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-134 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1229 Continued From page 3 1229 diet. On July 29, 2010, at 11:30 a.m., interview with the license practical nurse revealed that if a resident is ordered a finely chopped meal, they should not receive shredded vegetables. Review of the facility's in-service training records on July 30, 2010, at 9:50 a.m., revealed that all staff had received nutritional training on May 11, 2010. There was no evidence that training had been effective. 1379 3519.10 EMERGENCIES 1379 In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all incidents that present a risk to resident's health and well-being

Health Regulation Administration

The finding includes:

were reported immediately to the Department of

Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of three residents included in the sample. (Resident #3)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-134 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1379 Continued From page 4 1379 Review of Resident #3's nursing note dated April 5, 2010, on July 30, 2010, at approximately 1:00 I 379 p.m., revealed that a resident at the day program Direct Care Staff (DCS) and hit Resident #3 across the left side of his face. nurses will be re-trained on the Further review revealed that the facility's License facility's incident management Practical Nurse administered Tylenol for pain. policy. Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2010, at Such training shall be held approximately 2:30 p.m., revealed he was quarterly so as to enhance unaware of the incident. Further interview revealed there was no incident report completed. staff's understanding and At the time of the survey, there was no evidence competency in incident that the facility reported the incident of abuse to management policy and the administrator or to the Department of Health. procedure. 08/31/10 1401: 3520.3 PROFESSION SERVICES: GENERAL I 401 **PROVISIONS** Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services were provided in accordance with the needs, for one of three residents included in the sample. (Resident #3) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Review of Resident #3's physician's order (PO)

Health Regulation Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-134 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID Ю PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) I 401 Continued From page 5 I 401 from July 1, 2009, to July 1, 2010, on July 30, 2010, at 12:30 p.m., revealed an order for the I 401 resident to have laboratory studies for CBC and urinalysis every year. Subsequent review of his **Quarterly Audits will be** medical records revealed the last CBC study was conducted by the QA person May 27, 2009. There were no laboratory results on all habilitation records to available in the resident's record for a urinalysis ensure that all study. recommendations and medical Interview with the license practical nurse (LPN) appointments are followed up on July 30, 2010, at approximately 1:00 p.m., as recommended. 08/31/10 confirmed that the laboratory studies were not completed as ordered. 1405 3520.7 PROFESSION SERVICES: GENERAL 1405 **PROVISIONS** Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers. including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents residing in the facility. (Resident #2) The findings include: The facility failed to ensure that the day program implemented Resident #2's behavior support plan as prescribed. Observation at Resident #2's day program on July 28, 2010, at 11:31 a.m., revealed the

Health Regulation Administration

FORM APPROVED

PRINTED: 08/06/2010 Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-134 07/30/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1405 Continued From page 6 1405 resident leaning over the surveyor. At the same time, the qualified mental retardation professional (QMRP) told the resident he was too close and to give the surveyor her personal space. (Note: the QMRP came to the day program to give him his eye glasses). At 12:30 p.m., Resident #2 stood close to the surveyor and held her hand while she spoke with his day program staff. At no time did the day program staff request the resident to give the surveyor her personal space. Interview with the day program staff at 12:35 p.m., indicated that he is required to ask the Resident #1 to stand within arms length and to give individuals their personal space. I 405 Review of the day program behavior support plan A case conference will be held (BSP) dated October 20, 2009, at approximately with client #2's day program 12:40 p.m., revealed the following procedures for addressing Resident #1's target behavior of to discuss consistency in inappropriate social behavior: implementation of interventions specified in the a. Staff should, "ask him to utilize his string as a Behavior Support Plan (BSP). way to remind him of the appropriate distance." b. Staff should receive praise for initiating Twice monthly, for the next conversation in an appropriate manner. three months, the Qualified Mental Retardation c. If he continues his target behavior, staff should Professional (QMRP) will visit disengage, physically and conversationally, from him until he uses the appropriate behavior. client #2 at his day program to observe implementation of At the time of the survey, there was no evidence client #2's BSP. that the day program staff implemented Resident 08/31/10

#1's BSP.

1 420 3521.1 HABILITATION AND TRAINING

Each GHMRP shall provide habilitation and training to its residents to enable them to acquire 1420

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assessment.

a showering routine. The program should provide simple step by step directive for him to soap himself and use the shower head to wash off the soap. Review of the Individual Program Plan (IPP) dated October 23, 2009, on July 30, 2010, revealed no evidence of training programs to address the aforementioned recommendations

included in the comprehensive functional

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(1) verbal prompt.

in the evening.

During a face-to-face interview with LPN #1 on July 29, 2010, at approximately 7:45 a.m., revealed Resident #1 had a self-medication program however, the program was implemented

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verbal prompts, Resident #3 will get his cup and fill it with water when it is time for his medications.

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as evidenced below:

#1's family member for psychotropic medications

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